Structural Dissociation Model

Introduction

Dissociation is the process of emotional distancing often experienced by people undergoing a traumatic experience. It is also commonly experienced by clients during an abreaction to the trauma. This is distinct from Dissociative disorders, a much more serious condition characterised by splitting of the personality into parts - Structural Dissociation.

What follows is an account of the theory of Structural Dissociation described in "The Haunted Self", the classic text on this subject (1). For those who have the time, we recommend reading the full text – some 400 pages long - if possible. For those who are currently unable to do so, our aim is to introduce you to the main ideas of the theory and to encourage you to dig deeper into this important subject. In this account we have kept to the terminology used in "The haunted Self".

Dissociation - a survival strategy

Faced with abuse and neglect, children need to find some way of surviving psychologically. Abused children make use of the brain's capacity to split into parts. There may be a 'good child' who gets on with normal life as best as he or she can, and who 'disowns' the 'bad child', to whom the abuse and neglect happened, as 'not me'.

The Structural Dissociation model of personality posits splitting as an adaptive response to the demands of a traumatic environment. Moreover, it proposes that this response is based on the left brain/right brain split that supports 'disowning' of the 'not me' or trauma-related parts and supports the ability to function without awareness of being traumatised. This phobic avoidance between parts is a key characteristic of Structural Dissociation, and insensitivity to this by therapists seeking to treat trauma can be a cause of patients not returning to therapy.

Splitting causes the development of parts driven by animal defensives that are crucial to survival. The trauma related parts, activated by normal life stimuli and driven by implicit trauma responses, may experience threat or danger and automatically engage in defensive behaviours such as fight, flight, freeze, submit, and cry for help even when the threat of danger is long past.

Survival, but at a cost!

While this is a valuable survival strategy, it also comes at a cost. To keep the rejected part 'out of the way' long after the traumatic events have occurred, individuals must rely on dissociation, denial and/or self-hatred for enforcing the disconnection. In the end, they have survived trauma by disowning the most vulnerable and hurting parts of themselves.

Although the term 'parts of the personality' is a controversial concept in the mental health world, we will continue to use it in the videos you will see. There are three reasons for doing so: first, use of the term does suggest there is a *whole* person with whom we are working as therapists. Second, the term is in common usage – who has not said something like, "Part of me wants an ice cream and part of me says no, not today." So, it's easily understood by clients, at least in Western culture. Third, there is evidence that the brain develops neural networks that consist of neural pathways that consistently fire together, and that these neural systems can encode complex systems of traits or

systems that represent aspects of our personalities or ways of being. In other words, a 'part' may be represented by one of these networks as a physical reality in the brain of an adult.

Such neural systems can be complex with a subjective sense of identity or can be a much simpler collection of traits associated with different roles played by the individual. This is consistent with what most of us working with parts will have experienced. Some parts have a definite sense of identity and are quite elaborate in their ability to communicate, while others are much less so.

Outline of the structural dissociation model.

The structural dissociation model hypothesises that there are three types of structures that develop as a result of trauma:

1. ***Primary Structural Dissociation*** is the simplest division of the personality. There are just two parts. First, there is an 'Apparently Normal Part' (ANP) that carries out the action systems crucial to 'getting on with life'. The other part is called the 'Emotional Part' (EP), which holds the feelings and memories of the trauma and the mammalian defensive reactions related to it, including fight, flight, and freeze or tonic immobility (playing dead).

   This division seems to evolve most often in consequence of a single traumatising event, although it can also be observed in childhood abuse survivors in the form of the 'inner child' phenomenon. Primary structural dissociation is characteristic of simple trauma-related disorders, such as simple forms of PTSD, and some 'conversion disorders' (a mental condition in which a person has blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation).

   In primary structural dissociation the ANP is the major 'stakeholder' of the personality and maintains executive control most of the time. It carries out adult action systems crucial to survival, such as exploration, attachment, caretaking and sexuality. The EP is, most of the time, not in control, but can take full executive control during a flashback in which orientation to the present is lost, and the person is in a full reliving of an earlier trauma. An EP is a psychological structure that is a separate, dissociated biopsychosocial subsystem with reactivated traumatic memories that may involve feelings, various sensory perceptions or strongly held beliefs. In cases of PTSD, EP's are thought to be more rudimentary than in cases of Secondary and Tertiary dissociation.

2. ***Secondary Structural Dissociation*** is more complex and develops when traumatization is prolonged and repeated. The range of complexity can be very significant. The simplest form consists of two EPs and one ANP that involves the majority of the functioning of the personality. Other traumatised individuals become much more divided, with several to many EPs. These EPs may be present in various forms and may have quite varied degrees of separateness, autonomy, and elaborated characteristics such as name, age and gender.

3. ***Tertiary Structural Dissociation*** involves not only more than one EP, but also more than one ANP part. The model proposes that this form of dissociation is characteristic of Dissociative Identity Disorder (DID). In such cases the action systems crucial to 'getting on with life' such as exploration, attachment, caretaking and sexuality, which are found in a single ANP in primary and secondary structural dissociation, are now divided among two or more ANP's. As in some cases of secondary structural dissociation, some EP's may be more

complex and autonomous, appear in daily life, and take over full Executive control other than simply defence.

Trauma related symptoms

Most trauma survivors have a range of symptoms. Even those with 'simple' PTSD from a single incident trauma may have symptoms that go far beyond avoidance, re-experiencing and hyper-arousal, reflecting a range of somatic, cognitive, affective and behavioural effects of psychological trauma. Often, dissociation is viewed as simply one of many symptoms rather than as an underlying organisation of symptoms. In this summary we assume the latter, although it can be difficult to decide whether or not a particular phenomenon is a manifestation of structural dissociation or whether it is something else. For example, a different sense of self may be due to depression, exhaustion, intoxication or structural dissociation. The proof that symptoms are related to structural dissociation lies in showing that one part of the personality recalls a memory or experience that another part does not.

There are two classes of symptoms: *negative dissociative symptoms* relate to the *loss* of mental abilities such as perceptions, affects, memories, ability to focus, etc. Their counterpart consists of *positive dissociative symptoms,* such as intrusions of traumatic memories and voices. It's been noted that:

- *Negative symptoms* are more persistent and permanent over time – from the perspective of the apparently normal part of the personality (ANP), which has executive control most of the time.
- *Positive symptoms* tend to come and go with the intrusion of an emotional part of the personality (EP) into ANP. They include the intrusion symptoms of PTSD and other trauma–related disorders. In more complex cases, EPs may intrude into each other; and one ANP may intrude into another ANP in cases of DID.

While symptoms of structural dissociation may be understood as positive or negative, they can also be understood as symptoms that show up in two ways:

- Mentally, i.e. as *psychoform dissociative symptoms.*
- In the body, i.e. as *somatoform dissociative symptoms.*

Both psychoform and somatoform symptoms can be experienced by one part of the personality and not by another. The table shows a summary of how these ways of understanding symptoms can be brought together. It links the psychoform and somatoform symptoms with the negative and positive dissociative symptoms.

Type of symptom	Psychoform symptoms	Somatoform symptoms
Negative dissociative symptoms	**Dissociative amnesia** (Associated with chronic childhood abuse and neglect, especially if the abuser is a close relative or carer.) **Loss of critical thinking** (Critical thinking requires recognition of details and nuances, often impaired in trauma survivors. The ability may be available to certain parts of personality, but less so to other parts.) **Loss of mental skills** (Cognitive impairment includes problems with memory, concentration, attention, planning and judgment.) **Loss of affect** (Affect dysregulation is common in traumatised clients. It may occur because of switching among parts of the personality that experience diverse affects that are not integrated with each other. There may be a degree of emotional numbing in the present, so clients as ANP may complain of feeling two dimensional. It may also be an absence of emotion regarding the traumatic event, e.g. in total submission.) **Loss of needs, wishes and fantasies** (Survivors as ANP may have dissociated not only painful emotions, but also painful needs, for attachment, or wishes such as yearning for a good parent. These needs are often held by childlike EP's.)	**Loss of motor function** (Temporary or more permanent loss may include partial or total paralysis of limbs or the entire body, contractures, poor coordination, sudden loss of muscle tension, and loss of hearing, smell, taste, vision or speech. May occur in survivor as ANP, or in an EP fixated in freeze or in total submission.) **Loss of skills** (Loss of skills can involve both mental and behavioural actions When an EP has complete executive control, daily life skills of the ANP can often be missing.) **Loss of sensation** (Loss or diminution of sensation is a common feature of traumatised individuals. Loss may include sense of touch, pressure, temperature, pain, movement, arousal or other physical signals such as hunger or fatigue. Other manifestations include partial or complete loss of hearing, vision, taste and smell.)

Type of symptom	Psychoform symptoms	Somatoform symptoms
Positive dissociative symptoms	**Schneiderian symptoms** (Mental intrusions of one dissociative part into another are often interpreted by clinicians as evidence of the some of the Schneiderian 11 first-rank symptoms of schizophrenia. They include hallucinations, such as voices arguing or commentating and audible thoughts. Dissociated voices are usually experienced by the patient as emanating from *inside* the head, and can generally carry on a conversation with the therapist and with other parts of the personality. This is in contrast with voices of schizophrenia which come from the *outside*. Another common experience is the sense that thoughts have been "put in" or "pulled out" of their mind. This may be the experience of the ANP in executive control at the time, while insertion or withdrawal is in the control of an EP.) **Cognitive appraisals** (Dissociative parts may have different worldviews, sense of self and systems of beliefs. Confusing shifts in perceptions of people, situations and self may occur depending on which part is 'in control'.) **Fantasies and daydreams** (Presence of fantasy may sometimes constitute a positive symptom. For example, an ANP may fantasise about a loving family as a child, when the opposite was true.) **Alterations in relations with others** (As ANP, a survivor may value a particular person and treat them as a close friend. However, an EP may	**Schneiderian symptoms** (Positive somatoform dissociative symptoms include Schneiderian first rank symptoms of somatic passivity, such as the sense that the body is being controlled by someone else. Intrusions of traumatic memories generally have a sensory component. Thus, for example, traumatised individuals may have the sensation that their hands are tied or someone is holding them down. Other perceptual alterations may also be positive somatoform dissociative symptoms, including sensory hallucinations related to traumatic experience – the smell of petrol or blood after a car accident.) **Specific sensations/perceptions and motor or behavioural actions** (These are linked to various parts of the personality and not to others. Include, pain; intentional behaviour; repetitive, uncontrolled movements such as tics; and sensory perceptions – vision, touch, hearing, taste and smell. Re-victimisation is a positive dissociative symptom when dissociative parts of the personality are fixated in total submission or are reactivated and take control of consciousness and behaviour.)

	feel threatened by that and act with hostility. Such traumatized individuals may exhibit a disorganised attachment style.) **Alterations in affect** (Affect that may not be present in the survivor as ANP, may suddenly intrude in daily life from an EP in which the vehement emotions associated with traumatisation are re-experienced.)	

Trauma related alterations to consciousness

So far we have looked at a structural understanding of dissociation as a survival strategy for an individual who has experienced trauma and at the symptoms they might experience and display in life. The structural dissociation theory proposed more than an understanding of symptomology however, it also proposes changes to the level and field of consciousness.

Level and field of consciousness are altered to some degree for adaptive functioning, and happen every day in every person. For example, narrowing of the field of consciousness is necessary for focusing on a specific task and lowering the level of consciousness is necessary for a person to rest and sleep. In understanding the experience of trauma survivors, it is helpful to look in detail at two aspects of consciousness:

- ***Field of consciousness*** is the quantity of stimuli that are held in conscious awareness at a given time. Retraction of the field of consciousness, or narrowing of attention is characteristic of daily life for everybody. Yet it is also highly significant for both the ANPs and EPs of a dissociated person. In a dissociated person, dissociated parts recall some experiences and facts, creating episodic and semantic memories that may or may not be accessible to other dissociated parts. Alterations in consciousness brought about by the trauma can involve a *failure* to create such memories in any part of the personality.
- ***Level of consciousness*** – which can range from very high (hyper-alertness in face of danger), to very low (characteristic of impaired mental and behavioural action where important facts and experiences are not perceived or remembered). Lowering of consciousness can show in common situations such as concentration problems due to fatigue of illness as well as symptoms of depersonalisation, such as feeling unreal, detached or strange, derealisation and time distortions.

The field and level of consciousness work together at all times. Focused attention requires a combination of a voluntary narrowing (retraction) of the field of consciousness along with a high level of consciousness. Low levels of consciousness along with a wide or narrow field of consciousness result in conditions of spaciness or drowsiness, trance or unresponsiveness.

Normal versus Pathological alterations in consciousness can be difficult to discern**.** During threat, a high level of conscious awareness and a narrowing of the field of consciousness is adaptive. To maintain this state in everyday life even though there is no hint of danger, as happens with trauma survivors, is maladaptive and pathological. Some people need to "stare at the wall" when waking up as they transition into normal life in an adaptive way. To do this for hours on end, or if it cannot be voluntarily interrupted, is pathological.

Different dissociative parts can show varying degrees of alterations in field and level of consciousness at a pathological level, particularly survivors as EP. One part may be responsive while another is unresponsive. One part may only be aware of traumatic memories, while another may be going on with life and be engaged is a wide range of activities. ANPs and EP's may be aware of each other, but may narrow their field of consciousness to exclude each other.

During traumatic experiences, involuntary and severe alterations in consciousness are present at some point. These may be related to the development of structural dissociation, but may also occur without it. Thus, it's a mistake to assume alterations of consciousness are a sure sign of structural dissociation. Research seems to support the idea that lowering of consciousness differs from, but often accompanies dissociation.

Depersonalisation and Derealisation *are* phenomena that are common in many psychiatric conditions and are reported by a substantial proportion of the general population. This makes it difficult to determine whether symptoms of depersonalisation and derealisation are those of structural dissociation or not. Symptoms such as feelings of strangeness or unfamiliarity with self, a sense of unreality, such as being in a dream, and a sense of unreality with one's environment and distortions of time and space represent alterations in consciousness that may occur independent of structural dissociation.

On the other hand, depersonalisation symptoms are very common in traumatised individuals with different types of traumatisation, including all conditions from PTSD to complex dissociative disorders. Also, many dissociative parts of the personality experience symptoms of depersonalisation. ***A sound rule is that a symptom can only be said to be dissociative if there is clear evidence of dissociative parts of the personality, and the symptoms can be found in one part but not in others.***

The Dissociative Experience Scale (DES*)* (2)

This is one of the most common instruments used to investigate different kind of dissociative symptoms in both clinical and nonclinical samples. It consist of 28 items that assess the frequency and severity of a wide range of dissociative experiences using an eleven-point visual analogue scale (0%–100%). It includes items that address "non-pathological" and "pathological" changes in level of consciousness:

- "Non-pathological" items such as absorption (item 1 on DES) and imaginative involvement (item 18) do not stem from structural dissociation.
- In contrast, "pathological" items do stem from structural dissociation (item 3 and 27 on DES, for example). These items belong to the so called DES-T(axon) – eight items that predict DDNOS and DID better than DES. (The items are: numbers 3, 5,7,8,12,13, 22, and 27)

DES was developed to quantify dissociative experiences and as a screening instrument for dissociative disorders and for disorders with a significant dissociative component such as PTSD. It was developed for use with adults (persons 18 years and older. It was not intended as a diagnostic instrument.

High scores should not be construed as a definite indicator of Dissociative Disorder diagnosis. However, for clients scoring more than 20 on DES, or responding positively to the clinical signs in the table of symptoms shown earlier, the therapist should suspect the presence of a dissociative disorder. He/she should interview the client to find out more about the experiences that contribute to the high score.

Another option is to administer the Dissociative Disorders interview Schedule (Ross et al., 1990) and the Structured Clinical Interview (Steinberg et al., 1990). Similarly with DES-T. In such cases, the therapist should be able to make or rule out a dissociative disorder diagnosis.

To summarise, while most individuals who experience alterations in consciousness do not have structural dissociation, those who have developed structural dissociation will also have pathological alterations in consciousness. Alterations in consciousness are thus sensitive but not specific indicators of structural dissociation. Their presence may hint at structural dissociation but are not a direct indicator of it.

An introduction to treatment interventions

In simple PTSD which only includes the ANP and a rudimentary EP that holds the trauma memory, a straight forward use of the basic EMDR protocol usually suffices. Desensitisation and reprocessing usually restores the EP and effects union with the ANP. Patients become more adaptive in daily life and realise that their memories of their traumatic experience(s) are part of their life history and are not happening now.

However, for more chronically traumatised individuals, a phase oriented treatment as described by Pierre Janet more than a century ago, is required. This involves:

- Phase 1: stabilization and symptom reduction including an emphasis on skill building and improvement in mental level (see trauma symptom list above).
- Phase 2: treatment of traumatic memories, including addressing the typical phobic avoidance between parts, prior to any trauma processing with EMDR
- Phase 3: personality (re)integration and rehabilitation.

This phased treatment can be applied in a straightforward way in less complicated cases of secondary dissociation. However, in most cases of secondary and tertiary structural dissociation, treatment is long-term and the phase oriented model moves back and forth between the Phases. Phase 2 will be periodically alternated with Phase 1. Later in the therapy, Phase 2 and even Phase 1 will be alternated with Phase 3 work. This makes the therapeutic relationship central to the entire

process as the therapist needs to understand, respect and work with the constraints of the mental level of the patient and his or her dissociative parts of the personality.

A detailed account of this phase orientated model can be found in “EMDR Solutions, Pathways to Healing”, though the author uses different terminology to that in the “Haunted Self” (3).

(1) van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization. Norton & Co.,* New York

(2) Alexandra Richman (2005). *EMDR Part 1 Training Manual*.

(3) Robin Shapiro, (Ed.) (2005). *EMDR Solutions, Pathways to Healing.* Norton & Co., New York. See Chapter 3